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RESEARCH PAPERS

Differentiating Post-Traumatic Stress Disorder (PTSD) from Major Depression (MDD) and Generalized Anxiety Disorder (GAD)

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Abstract —Questions about the differential diagnosis of Post-Traumatic Stress Disorder (PTSD) have been raised since this category was reformulated in *DSM-III* (Spitzer, 1980?1?). Clinicians have reported difficulties distinguishing PTSD from other categories, particularly from Major Depressive and Generalized Anxiety Disorders (MDD and GAD). Diagnostic validity can be established in several ways (e.g., through clinical descriptive studies, laboratory experiments, family history studies, etc.). In this paper, we describe one approach to validation thus far not applied to PTSD. This approach centers directly on whether clinicians can distinguish PTSD from other diagnostic categories. Experienced clinicians were asked to rate the extent to which a common set of 90 symptom items characterized PTSD, MDD, and GAD. Ratings were analyzed with

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An appendix for this paper is available from the authors upon request, providing a list of items, factor structure of the instrument, and authors' predictions of diagnostic class membership. It might be noted that only the list of symptoms were made available to the subjects, not the source nor our diagnostic predictions.

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multivariate and univariate analyses of variance and covariance, multiple discriminant function analysis, and factor analysis; moreover, characteristics of raters were examined for possible influences. Results indicated that clinicians readily distinguish PTSD from MDD and GAD as well as MDD from GAD. Findings are presented in terms of univariate analyses, 34 best discriminating items, and factors specifying dimensions differentiating the syndromes of PTSD, MDD, and GAD. Rater characteristics did not influence diagnostic accuracy, although significant differences in magnitude of symptom intensity were found.© 1997 Elsevier Science Ltd

Mental health professionals agree that diagnostic criteria for classifying Post Traumatic Stress Disorder (PTSD) can be difficult to apply (e.g., ?1?Newman, Kaloupek, & Keane, 1996; ?1?Trimble, 1985; Van Kampen, Watson, Tilleskjor & Vassar, 1986). Consequently, some have challenged the validity of PTSD as a diagnosis and question whether PTSD can be distinguished reliably from other disorders (e.g., Goodwin & Guze, 1984). Specifically, differentiating PTSD from Major Depressive Disorder (MDD) and from Generalized Anxiety Disorder (GAD) is considered one of the more difficult diagnostic discriminations to achieve (e.g., Tuma & Masur, 1985; ?1?Yehuda & McFarlane, 1996).

The source of the controversy regarding the diagnosis of PTSD is difficult to identify, but may include some or all of the following circumstances: (a) PTSD shares so many symptoms with other disorders, such as MDD and GAD, that it is difficult to demonstrate that PTSD is unique; (b) PTSD develops more frequently among people more vulnerable to deleterious effects of a traumatic stressor, making it difficult to distinguish predisposing risk factors from subsequent reactions to a life-threatening trauma; (c) PTSD, particularly untreated PTSD, may give rise, over time, to other disorders, thus complicating differential diagnoses because it is hard to separate original PTSD symptoms from subsequent problems (cf. Keane & Kaloupek, in press); and (d) PTSD often exists with other disorders (Keane & Wolfe, 1990). Whatever the responsible factors, PTSD, for some, has remained an elusive disorder, far easier to specify in the abstract than to pinpoint in the concrete.

Problems in establishing reliable and valid diagnostic criteria are not unique to PTSD, however (?1?Skinner & Blashfield, 1982; Sutker, Uddo, & Allain, 1991). The histories of psychiatry and psychology are replete with debates about classification, the subjects ranging from differential diagnoses of the schizophrenias (Robins & Guze, 1970), the depressions (Feinberg & Carroll, 1982), to distinguishing hysteria from neurological disorders (Ziegler, 1967). The regularity with which diagnostic criteria are revised attests to persisting and continuing needs within the behavioral sciences to refine and, hopefully, to perfect indicators by which we understand patients and clients.

Problems in diagnosing PTSD also may occur because that group of symptoms currently called PTSD has varied in importance across diagnostic nomenclatures promulgated throughout the years. The concept of PTSD has waxed and waned in prominence, in part, as a function of professional and public

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sensitivities to the aftermath of war and other catastrophes (Herman, 1992). "Traumatic War Neuroses" were given major recognition, following World War II, the Holocaust, and the Korean Conflict, in the Gray Manual (*DSM-I*; APA, 1952), but gave way to less recognition when re-formulated as "transient situational stress reactions" in the Gold Manual (i.e., *DSM-II*; APA, 1968), only to re-emerge, but not without controversy, as "PTSD" in the Green Manual (*DSM-III*; APA, 1980 published shortly after the Vietnam War and a resurgence of interest in such world tragedies as the Holocaust and the effects of sexual assault).

When a new syndrome is introduced, or, as in the case of PTSD, when an ignored syndrome suddenly is re-discovered, empirical investigations of various sorts must be undertaken to establish diagnostic reliability and validity of the disorder (see Keane, Wolfe & Taylor, 1987; Robins & Guze, 1970). Several research strategies are needed, ranging from clinical descriptions, experimental laboratory studies, follow-up and treatment outcome evaluation, and family studies.

In this report, we address questions about the validity of PTSD by yet another research strategy, one that asks, "Can PTSD be distinguished from other previously-validated disorders which may have either greater prevalence or greater clinical utilization?" Specifically, we studied ratings by clinicians conducting diagnostic differentiations. We asked clinicians experienced in diagnosing PTSD to identify those dimensions that characterize PTSD. To make the task more compelling (and more manageable), we selected for comparison two diagnostic categories with which PTSD supposedly is more likely to be confused, i.e., Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD). We requested clinicians to rate these three disorders on a common set of symptoms (or items) for the degree to which each symptom (or item) characterized each of the three targeted diagnoses. The purpose of this study, then, was to determine whether experienced clinicians could differentiate PTSD from other major disorders and, if so, to identify dimensions for such differentiations.

METHOD

Instrument Development

A rating instrument was constructed in the following manner to assess the degree to which clinicians could differentiate PTSD from MDD and GAD. Ninety items were selected in total, with 80 symptoms from DSM-III-R diagnostic criteria and associated features for all three disorders, and 10 of items included as distracters or items assumed not to be directly related to any of the three disorders under investigation. Clinicians then rated each item separately for each diagnostic category (i.e., PTSD, MDD, and GAD) on the extent to which that symptom characterized the disorder. Eleven of the PTSD

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items are diagnostic criteria and nine are associated features. Fourteen of the MDD and 19 of the GAD items are diagnostic criteria. In addition, several items are part of the diagnostic criteria for more than one disorder: eight items are diagnostic criteria for both PTSD and MDD: three items are criteria for PTSD and GAD seven are diagnostic criteria for GAD and MDD, and five are common diagnostic criteria for all three disorders. The 10 distracter items were hypothesized to be unrelated to PTSD. A pilot study (N = 10) yielded few changes in instructions or item presentation.

Procedure

Veterans Affairs Medical Centers (VAMC, N = 154) across the country were contacted for possible participation in this study. A letter was sent to both the Chief of the Psychiatry Service (N = 147) and Psychology Service (N = 154) of each VAMC asking for their selection of up to three staff members experienced in making PTSD, MDD, and/or GAD diagnoses (preferably one "expert" clinician per disorder). Instructions to subjects (i.e., expert clinicians) were to rate prevalence of each of the 90 symptoms for each of the three disorders. Ratings were completed on a 0–4 Likert-like scale, where 0 = characteristic of less than 20% of patients with this disorder; 1 = characteristic of 21 to 40%; 2 = characteristic of 41 to 60%; 3 = characteristic of 61 to 80%; and 4 = characteristic of greater than 80% of patients with the disorder. Importantly, subjects were instructed to rely upon their own experience and not upon what others have said are the defining elements of PTSD, MDD, and GAD. To increase rate of participation, subjects were requested to remain anonymous. A brief demographic questionnaire, along with PTSD, MDD, and GAD rating scales for each of 90 items, comprised the entire task and could be completed in about 45 minutes.

Subjects

Of 897 rating instruments mailed, 340 were completed and returned in a timely fashion (i.e., 38% of the maximum possible responded). Thirty others were returned, but were unusable for a variety of reasons. The sample consisted of 148 psychiatrists and 192 psychologists. Approximately 84% were male. Average age of raters was 44.44 years, psychiatrists averaging slightly older than psychologists (45.19 vs. 43.47). The majority of the sample was white (91.24%). Seventy-two percent of psychiatrists were board certified, and 6% of psychologists were diplomats. Forty-five percent of the psychiatrists were military veterans (5% being combat veterans and 1% were Vietnam combat veterans). Fewer psychologists were veterans (21%), 4.4% reporting combat experience and 2% being Vietnam Era veterans.

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RESULTS

The question, "Can clinicians differentiate PTSD from MDD and GAD?" was addressed by analyzing whether significant differences occurred when clinicians rated the same 90 descriptors for each of three disorders. These ratings were analyzed in several ways. First, multivariate and univariate analyses of variance were performed to test whether ratings do, indeed, differ among the three disorders. Second, multiple discriminant function analysis was performed with a stepwise multiple regression procedure to identify a linear combination of items that best differentiate the three sets of ratings. Third, factor analyses were performed for each of the three sets of ratings for purposes of identifying dimensions that are common and unique for the three disorders (PTSD, MDD, and GAD ratings were considered separately, as well as for scores averaged across the three groups of ratings). Fourth, correlations were calculated to determine if PTSD, MDD, and GAD ratings were influenced by rater characteristics. Characteristics tested were: gender, age, profession, board-certified versus nonboard-certified, years of mental health experience, clinical experience with DSM criteria, time spent delivering direct clinical care, military-history taking experience, and military and combat experience, along with service era. Sequence in data analysis was to ask, first, whether clinicians could differentiate the three diagnostic categories; next, to identify those items that best produced such differences; then to specify dimensions of differences; and, finally, to rule out possible rater confounds that might obscure diagnostic differentiation.

Multivariate and Univariate Analyses of PTSD, MDD, and GAD Ratings

Ratings by 340 clinicians for each of the three disorders produced significant differences in overall ratings, using multivariate analyses of variance (i.e., MANOVA *F*). Univariate analysis of variance results are presented in Table 1, followed by means and standard deviations for one-way analysis of variance (ANOVA) by item for each of the three diagnostic categories, PTSD, MDD, and GAD. Clinicians rated PTSD significantly higher on 31 of 90 items. [Clinicians rated as significantly higher the 14 items predicted as unique for PTSD (i.e., the *DSM* criteria specific to PTSD) and eight of nine items considered as associated features of PTSD. The one exception was the item "feeling afraid in open spaces or on the streets," which was rated significantly higher for the GAD condition. Eight of the nine PTSD items expected to overlap with the MDD category were rated significantly higher than GAD symptoms; only "having to check and doublecheck what you do" averaged significantly lower. On four of the items expected to be shared with GAD, symptoms were rated in the anticipated direction as higher than MDD symptoms. Items on which PTSD ratings were unexpectedly higher were: "restlessness" (but not significantly different for GAD ratings) and "fear of loss of control."

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TABLE 1
STEPWISE REGRESSION ANALYSIS (ITEMS DIFFERENTIATING AMONG PTSD, MDD, AND GAD)

Step	Item	Symptom	R^2	F	p	*Lambda*
1	76.	Suddenly acting or feeling as if an event were recurring	72	969.90	.0001	.279
2	49.	Feeling blue	57	486.18	.0001	.121
3	54.	High respiration rate	45	300.15	.0001	.067
4	62.	Having urges to beat, injure or harm someone	26	129.34	.0001	.050
5	89.	Significant weight loss	25	124.34	.0001	.037
6	9.	Feeling afraid of fainting in public	18	78.84	.0001	.031
7	48.	Startle responses	16	72.39	.0001	.026
8.	20.	Distressing memories of the death of another	14	58.09	.0001	.022
9	19.	Feeling tense	12	51.60	.0001	.020
10	2.	Markedly decreased interest in activities formerly considered important wrong with one's body	08	32.87	.0001	.018
11	67.	The idea that something is	07	27.03	.0001	.017
12	11.	Substance abuse	07	26.01	.0001	.016
13	1.	Overeating	07	27.58	.0001	.015
14	45.	Suicidal attempt	07	26.74	.0001	.014
15	41.	Recurring dreams of an event that happened	07	26.04	.0001	.013
16	10.	Feelings of guilt	05	18.24	.0001	.012
17	15.	Heart pounding/racing	04	14.58	.0001	.012
18	26.	Feeling low in energy or slowed down	03	12.45	.0001	.011
19	78.	Having to repeat the sameactions such as touching, counting, washing	03	12.61	.0001	.011
20	7.	Having to avoid certain things, places, or activities because they are anxiety-producing	03	10.17	.0001	.011
21	68.	Delusions	03	9.20	.0001	.010
22	23.	Thrill-seeking	02	8.03	.0004	.010
23	43.	Thoughts of ending life	02	5.53	.0041	.010
24	24.	Difficulty in feeling close to someone	02	5.78	.0032	.010
25	25.	Having thoughts about sex that bother you a lot	02	6.01	.0026	.010
26	18.	Worrying	02	6.11	.0023	.010
27	27.	Poor appetite	01	3.94	.0199	.009
28	3.	Dissociative phenomena	01	4.07	.0174	.009
29	65.	Feeling afraid in open spaces or on the streets	01	3.92	.0202	.009
30	81.	Grief over loss of another person	01	3.53	.0295	.009
31	71.	Trouble falling asleep	01	3.72	.0247	.009
32	6.	Having to check and double check everything that you do	01	3.26	.0391	.009
33	78.	Hypervigilance.	01	3.05	.0480	.009
34	69.	Trouble remembering things	01	3.17	.0425	.009

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Such differences strongly confirm predictions that clinicians can readily differentiate symptoms of PTSD from symptoms of MDD and GAD. Item-specific differences conformed to predictions derived from *DSM-III-R* criteria. Not only did clinicians rate PTSD symptoms as different from MDD and GAD symptoms, but items for which differences occurred were precisely those that were both unique to PTSD and for which PTSD was expected to overlap with MDD and GAD.

The precision with which raters decisively distinguished PTSD from MDD and GAD is further confirmed by the clarity with which both MDD and GAD diagnostic categories were differentiated. Ratings are significantly higher in 14 of 15 items anticipated to be unique for MDD. Clinicians rated MDD significantly higher than PTSD and GAD on 29 items. MDD ratings were highest on 7 of 18 items thought to overlap with either PTSD and/or GAD, and ranked second highest on 8 of 18 items predicted to overlap with one of the other diagnostic categories. "Misses" (i.e., not correctly predicting item relationships) occurred for only five symptoms. These were all distracters items for which predictions were not made and for which mean ratings were expectedly low.

Clinicians rated 27 items significantly higher for GAD. Sixteen of 17 were in the predicted direction. The item, fatigability, rated as more characteristic of MDD than GAD, was the 1 miss out of a possible 17. Of the 15 predicted descriptors that the GAD category was expected to share in common with either PTSD and/or MDD, 14 mean ratings were in the expected direction. The item "having to avoid certain things, places, or activities because they are anxiety-provoking" was the lone miss in prediction (i.e., mean ratings were 0.68, compared to 3.29 for PTSD and 2.55 for MDD. Mean GAD category ratings were higher for seven items in ways that were unpredicted. Detailed examination, however, shows that mean GAD ratings do not differ significantly from MDD on the item "overeating," and that four of the items were "distracter" items for which predicted directions of either PTSD, MDD, or GAD were not made (i.e., "feeling afraid of fainting in public"; "having thoughts about sex that bother you a lot"; "feeling low in energy or slowed down"; "bulimia"; and "having to repeat the same actions such as touching, counting, washing"). In summary, the clinicians were exceptionally accurate in their depiction of which symptoms were most strongly associated with each of the three disorders.

Multiple Discriminant Function Analysis of PTSD, MDD, and GAD Ratings

In order to specify which items in combination best discriminated among the three groups, ratings were subjected to a multiple discriminant function analysis procedure with stepwise multiple regression analysis. Two discriminant functions were significant: Canonical correlation for the first is 0.963, $F(188, 1320) = 78.23$, $p < .00001$ and 0.948 for the second, $F(89, 661)$ 66.33, $p < .00001$.

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Diagnostic group means in the canonical discriminant analysis for the first standardized canonical coefficient are: PTSD, 4.71; MDD, -3.37; and GAD, -1.82 and for the second are: PTSD, 0.70; MDD, 3.23; and GAD, -4.09. The first discriminant function varies in activity-passivity where dealing with disturbing thoughts and vulnerability to one's emotions characterizes the positive end of the continuum (e.g., "Having urges to beat, injure, or harm someone"; "Suddenly acting or feeling as if an event were recurring"; "Substance abuse"; "Recurrent dreams of an event that happened"; "Distressing memories of the death of another"; "Hypervigilance"; "Difficulty feeling close to someone"; and, "Having to avoid certain things, places, or activities because they are anxiety provoking") and flight from problems (or avoidance) typifies the negative (i.e., "Overeating"; "thoughts of ending life"; "the idea that something is wrong with one's body"; and "feeling afraid of fainting in public"). Whereas PTSD ratings loaded on the positive end, MDD and GAD ratings loaded on the negative. The second discriminant function ranges from symptoms of depression to symptoms of anxiety. Items positively loading are Feeling blue," "Markedly decreased interest in activities formerly considered important," "Feelings of guilt," "Distressing memories of the death of another," and "Significant weight loss." Items negatively loading are: "Feeling afraid of fainting in public," "Feeling tense," "Heart racing/pounding," "Startle response," "High respiration rate," and "Having to repeat the same actions such as touching, counting, washing." Expectedly, MDD ratings loaded positively and GAD ratings load negatively.

"Hit rates" for classifying cases using these two discriminant functions are: PTSD, 100%; MDD, 100%; and GAD, 99.63%.

A forward stepwise procedure was also performed to remove redundant items and to select the better set of items providing greater diagnostic univariate discrimination (see Table 1). Thirty-four of the 90 items considered in combination yielded correct classification rates similar to those indicated above. These items reflect the characteristics that clinicians regard as relatively more important when differentiating among three prototypic diagnostic classes. Results both show that clinicians can differentiate PTSD from MDD and GAD and also specify those characteristics considered most important in carrying out such discrimination (Horowitz, Wright, Lowenstein, & Parad, 1981, on the prototype as a construct in clinical psychology).

Factor Analysis of PTSD, MDD, and GAD Ratings

Factor analyses were performed for each of the three sets of ratings and for the total sample combined using averaged ratings for each of 90 items. Only the latter analysis is reported here, since factorial structures were comparable under all comparisons. Factor analysis was selected to determine the minimum number of hypothetical factors (or dimensions) that clinicians used in differ-

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entiating PTSD, MDD, and GAD and to produce factor scores from clinicians' ratings about prototypes of PTSD, MDD, and GAD (cf. Horowitz et al., 1981).

Seven factors were found: Factor 1, an autonomic, physiological reactivity measure, primarily associated with GAD; Factor 2, fears about what might happen in the future — a troubled, pessimistic thinking variable, primarily associated MDD; Factor 3, fears about what actually happened in the past — a troubled thinking variable of ruminations over distressing past events, primarily associated with PTSD; Factor 4, a disordered thought variable, primarily associated with MDD; Factor 5, a concern over controlling direct expression of anger and aggression, primarily associated with PTSD; Factor 6, disturbances in appetitive functioning, associated with MDD; and Factor 7, anxieties about losing control over consciousness, primarily associated with GAD. Similar factors emerged when clinicians' ratings were considered separately for each diagnostic disorder. Thus, there is no separate factor structure for the instrument when it is employed across the three disorders or when employed for each separately.

Clinician Characteristics Influencing Ratings of PTSD, MDD, and GAD

Characteristics of clinicians were analyzed to see if ratings differ by dispositional and situational characteristics of raters and to see if such differences explain why some clinicians have not concurred that PTSD is independent of MDD and GAD. Gender differences were found; females rate the three disorders higher than males. However, "hit rates" in differentiating PTSD, MDD, and GAD were identical. Combat experienced clinicians rated symptoms significantly lower than raters without combat experience. However, both groups differentiated the diagnostic categories to similar degrees. Similarly, psychiatrists rated symptoms lower than psychologists. Those with more professional experience rated symptoms lower than those with less experience. Importantly, differences in ratings by subgroups of clinicians were simply differences in degree, but not differences on items or in differentiating PTSD, MDD, and GAD.

DISCUSSION

These results, then, provide yet another form of construct validation for PTSD in at least two ways. First, a clinical disorder readily recognizable as unique to PTSD clearly emerged through ratings of clinicians. Elements of this disorder appear to be the traditionally accepted cluster of problems that (a) a person presents evidence of re-experiencing life-threatening events both while awake and even while asleep; (b) that such persons remain in a condition of heightened arousal; (c) that such persons periodically act in ways to demonstrate their anger and frustration about having experienced such life-threatening

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events; and (d) that such persons act to avoid recollections of such life-threatening experiences that are personally and palpably painful.

Secondly, construct validation was established by demonstrating that PTSD is readily distinguished from the two disorders with which PTSD supposedly is easily confused (i.e., MDD and GAD). Clinicians distinguish PTSD by the situation-specific nature of its symptom-complex (i.e., by linking current symptoms with past traumatic events) and by symptoms of avoidance with regard to present reminders of past traumatic events. PTSD is distinguishable from MDD by higher ratings on items that describe increased interactions with current activities that do not remind one of past traumas: in contrast, MDD is rated as significantly higher in inactivity for all kinds of stimuli (i.e., ratings about MDD as a disorder characterized by loss of energy and loss of hope). PTSD is distinguishable from GAD by the situation-specific link between current physiological reactivity and memories of past traumas. GAD was rated as a disorder marked by widespread and intense physiological reactivity across a broad band of stimuli: physiological reactivity in PTSD was specific to trauma and memories of trauma. In addition, PTSD, by contrast with MDD and GAD, emerges as a disorder associated with fears of acting out one's anger and frustration in response to the lingering and terrifying effects of trauma exposure.

Our findings, however, are limited by the form of construct validation selected by which to conduct this study-namely, asking clinicians to rate in general which symptoms (or signs or problem indicators) they considered as representative each of the three disorders. That is, clinicians did not rate actual patients: they rated their memories about the modal patient typical of each of these three disorders. Thus, this form of construct validation was more a demonstration of the acquired experience of expert clinicians than an empirical verification of the behavioral indicators of PTSD (Zimering, Caddell, Fairbank & Keane, 1993). However, we have shown, minimally, that clinicians can agree upon verbal indicators about PTSD and these findings add support to studies that have supported PTSD by other forms of validation.

This construct validation probably is also limited to "prototypical types" of these three disorders and, again, may not generalize to cases of co-existing disorders. Research on PTSD has not been sufficiently refined that empirical studies have begun to take into account possibilities of differential manifestation of symptomatology as a function of differences in (a) pre-existing, pre-trauma differences in cognitive maturity and personality integrity; (b) co-occurring Axis I disorders (such as MDD with melancholic features over losses); and (c) subsequently occurring complications following untreated PTSD (e.g., Substance Abuse; see Keane & Kaloupek, in press).

The construct validation also may be limited to persons seeking treatment. Present findings were obtained from raters experienced in diagnosing PTSD in hospitals and clinics. Accordingly, current findings may not generalize to manifestations of PTSD (and MDD and GAD) outside of these settings. Future research obviously needs to include the study of PTSD among traumatized

persons who have not sought treatment and who were traumatized by other types of stressors (i.e., rape, disaster, etc.).

Finally, whereas current findings clearly corroborate hypothesized characteristics of PTSD and distinguish it from prototypes of other disorders, nevertheless it must be noted that raters differed not in kind but in degree when rating symptoms. Specifically, younger clinicians rated PTSD symptoms more intensely than did older clinicians; combat-experienced clinicians rated PTSD symptoms less intensely than did noncombat-experienced clinicians. Perhaps controversies about PTSD arise more from differences in raters than from difficulties in defining the disorder: effects of attitudes about trauma certainly influence intensity in ratings. Such differences in clinicians' backgrounds merit systematic examination among disciplines devoted to developing theoretical and practical standards by which human behavior is evaluated. Tests of such notions are currently underway in more complex post-hoc analyses of rater influences.

The findings, in sum, provide further evidence that PTSD can be distinguished from other longstanding and frequently-used Axis I disorders; PTSD consists of unique symptoms that clinicians can reliably differentiate from other symptom complexes. Empirical support for differentiating between MDD and GAD was also provided by these findings. Considering research on other DSM categories, this study marks an introductory effort to demonstrate that a particular diagnostic class indeed differs from other diagnostic categories. More work is needed on discriminating diagnostic categories from one another.

The process of developing diagnostic criteria for psychiatric nomenclature has not included direct tests of the extent to which one category can be reliably and validly distinguished from others. This study has demonstrated that PTSD is a useful addition to the diagnostic nomenclature. PTSD is distinguishable from other Axis I categories. PTSD is a viable diagnostic entity that lends increased precision to the diagnostic enterprise in mental health.

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